OSSEO AREA SCHOOLS
ISD 279

APPENDIX J
AUTHORIZATION TO RELEASE/OBTAIN PRIVATE DATA

School	School Address	School Phone Number

A. Student/Patient Name: _____ Grade_____ Birthdate_____

Address: _____

Parent/Guardian Name (if student is under 18 years old): _____

Address/Telephone Number (if different than student's): _____

B. I authorize _____ _____
Name, Title *Name of Organization*

_____ _____ _____
Address *Phone Number* *Fax Number*

C. **Purpose: To coordinate services and assist in the student's educational** (check one or both)

☐ To **release** written and verbal information to **and/or** ☐ to **obtain** written and verbal information from
Check both boxes if consenting to two-way conversation/written health information.

_____ _____ _____
Name, Title, worksite of Osseo Area Schools Representative *Phone Number* *Fax Number*

D. Indicate only the information that you are authorizing to be released:

1. ☐ Specific dates/ years of treatment _____
   a. ☐ Mental Health Assessment/ Diagnosis
   b. ☐ Care Plan
   c. ☐ Medical Report(s)
   d. ☐ Chemical Abuse/Dependency Report **(student consent needed if student is 18 years-old or older)**
   e. ☐ Educational Records (including Special Education Records)
   f. ☐ Counseling Report
   g. ☐ Social Work Report
2. ☐ Ongoing exchange of health information
3. ☐ *Other (specify)*_____
4. ☐ Other (*specify)*_____

- I understand that by signing this form, I am requesting that the health information specified above be sent to the organization I have named above.
- I understand that the laws that protect the information identified on this release, in some situations, may allow or require this entity to re-disclose this information, but only as permitted by law, according to the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Minnesota Government Data Privacy Act (MGDPA), Minnesota Statutes Chapter 13, and may no longer be protected by any federal or state laws.
- I understand that if the organization named above is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form.
- I understand that this consent takes effect the day that I sign it. My consent applies only to information available on the date of my signature unless I checked Section D2 above (the authorization for ongoing discussion of my health information).
- I understand that by signing this consent that upon request, the district will provide a copy of the records disclosed to me as the parent/guardian /adult student.
- I may change this consent or authorization at any time by sending a written notice of the change to the releasing school.
- If I do not change this consent or authorization it will expire one year from the date of my signature.

_____
Parent/Guardian or Adult Student Signature *Date*

This release of information complies with Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act. (FERPA)